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	175338	A. BUILDING _____ B. WING _____	10/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BALDWIN HEALTHCARE & REHAB CTR	1223 ORCHARD LANE BALDWIN CITY, KS 66006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156	Continued From page 1 under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and	F 156		

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F 156	Continued From page 2 provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: The facility identified a census of 51 residents. The sample included 22 residents. Based on interview and record review for 3 of 3 residents sampled for liability notices, the facility failed to provide a liability notice that included the Quality Improvement Organization (QIO) contact information and the services that would no longer be covered related to the change in Medicare services. (#53, #73, #26) Findings included: - The facility identified residents #53, #73 and #26 discharged from Medicare services.	F 156		

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F 156	Continued From page 3 Review of the liability notices the facility provided to residents #53, #73 and #26 revealed the facility failed to list the QIO contact number and the type of services that would no longer be covered under the Medicare services on the residents liability notices. During interview on 10/4/12 at 2:03 P.M. Social Services staff R acknowledged the QIO number was not listed on the liability letters and failed to indicate the specific service that would no longer be covered by Medicare. He/She was not aware that information was needed on the form. The facility failed to provide the necessary information on the liability notification provided to 3 residents.	F 156		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: The facility identified a census of 51 residents. Based on observation, record review and interview, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable environment in resident rooms on 3 of 3 halls. Findings included: - Observation in the 100 hall revealed 4 of 7	F 253		

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resident rooms and bathrooms contained personal hygiene and care items on the floors of the bathrooms, resident care equipment not bagged, bathroom walls lacked paint, torn walls, separating floor tiles and a very strong urine odor in one room.

During an interview on 10/3/12 at 2:10 P.M., housekeeping staff S stated nursing staff placed the resident personal care items on the bathroom floor, and he/she though the housekeeping staff picked the items up to clean under them.

During an interview on 10/3/12 at 2:10 P.M., maintenance staff T stated he/she checked the resident rooms monthly and fixed the problems right away, but did not keep records so he/she did not know the dates when he/she identified and fixed room problems.

During an interview on 10/3/12 at 2:14 P.M., administrative staff A acknowledged the personal care items on the floor, uncovered care equipment, walls torn and lacked paint, floor tiles and urine odor, and stated the resident environment was a Quality Assurance issue and several management staff monitored the resident rooms for problems.

During an interview on 10/3/12 at 2:18 P.M., housekeeping staff S acknowledged the strong urine odor in 1 resident bathroom, stated he/she expected staff to clean the bathroom 2 times per day, and stated, "That is the best we can do." Housekeeping staff S stated he/she monitored the housekeeping staff by walking the halls and checking rooms.

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F 253	Continued From page 5 Observation on the 200 hall on 10/3/12 at 2:28 P.M. revealed 3 of 10 resident rooms had chipped paint on the ceiling vent, unpainted ceilings, water stains on the ceiling and personal hygiene care items on the bathroom floor uncovered. During an interview on 10/3/12 at 2:28 P.M., administrative staff A acknowledged the chipped paint, lack of paint, water stains and personal care items on the floor. Observation on 10/3/12 at 2:32 P.M. on the 300 hall revealed 2 of 8 resident rooms contained wheelchairs or Broda chairs (a specialty wheelchair)that had soiled foot rests and soiled chair sides containing dried crusted food debris. The 300 hall shower room walls had orange stains on the length of 1 wall, and gray stains on the bottom of another wall. During an interview on 10/3/12 at 2:32 P.M., administrative staff A acknowledged the soiled wheelchair and Broda chair, and the stained shower room walls. During an interview on 10/3/12 at 2:36 P.M., housekeeping staff S stated staff tried to clean the stained shower room walls, but could not remove the stains. During an interview on 10/3/12 at 2:50 P.M., administrative nursing staff B stated staff should not place residents personal hygiene care items on the floor. The facility provided the policy entitled Maintenance Polices & Procedures dated 1/1/03	F 253		

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F 253	Continued From page 6 which directed staff to paint all rooms as needed and annually, and maintenance staff was responsible for minor repairs and touch ups. The facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable environment in resident rooms and common shower room.	F 253		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: The facility identified a census of 51 residents. The sample included 22 residents. Based on observation, interview and record review the	F 279		

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facility failed to complete a comprehensive care plan for 2 of 22 sampled residents, 1 regarding activities of daily living (ADLs) (#28) and for 1 resident regarding hospice (#22).

Findings included:

- Resident #28's Quarterly Minimum Data Set (MDS) 3.0 dated 9/16/12 recorded the resident with a Brief Interview for Mental Status score of 13, which indicated the resident was cognitively intact. The resident required extensive assistance for personal hygiene.

The Annual MDS dated 2/26/12 documented the resident with no dental problems.

The Comprehensive Care Plan last reviewed on 9/21/12 for ADLs did not address the resident's use of dentures, partial plate or the amount of staff assistance required for dental care. The care plan also failed to address the use of a lap table on the resident's wheelchair and padded bootie on the resident's left foot.

The October 2012 Physician's Order Sheet ordered staff to provide a mechanical soft diet for the resident.

The Nutritional Assessment dated 3/17/11 documented the resident with dentures, a partial upper and natural teeth on the bottom.

The Dental/Oral Assessment dated 4/3/12 documented the resident with missing teeth, wore dentures and a partial, no missing teeth on the dentures and no problems with the way the dentures fit. The assessment did not identify any

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F 279	Continued From page 8 problems with the resident's ability to chew. During resident interview on 10/01/12 at 4:05 P.M. he/she reported poor fitting dentures, missing teeth and problems chewing food. During observation on 10/3/12 at 12:59 P.M. staff served the resident ham cut up in bite size pieces, roll, pudding and vegetables. The resident fed himself/herself the meal and ate slowly. The resident reported the ham was good, but his/her jaw hurt. He/She wore dentures, a padded bootie on the left foot and had a tray table on the left side of the wheelchair During staff interview on 10/3/12 at 5:05 P.M., licensed nursing staff E reported no knowledge of the resident wearing dentures. Staff brushed the resident's teeth for him/her. During interview on 10/4/12 at 1:41 P.M., administrative nursing staff B reported the resident had dentures and required assistance from staff for oral care. He/She reported no knowledge of the resident's dentures fitting poorly. Staff placed the resident's half lap tray on the wheelchair on 9/15/11 and staff provided the resident the pressure relief bootie was placed by staff. He/She acknowledged the care plan instructed staff to use pressure relieving and assistive devices, but was not specific for this resident and did not address the resident's dental needs. The facility failed to develop a comprehensive care plan to address this resident's assistive devices and oral care needs.	F 279		

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- Resident #22's admission Minimum Data Set 3.0 (MDS) dated 4/15/12 documented a Brief Interview for Mental Status score of 12 which indicated the resident with moderately impaired cognition. The MDS documented the resident required extensive assistance of two staff with bed mobility and transfers and limited assistance of one staff with dressing, eating, personal hygiene, toileting and bathing. The assessment recorded the resident received hospice services.

The pressure ulcer Care area Assessment (CAA) dated 4/5/12 documented the resident with a terminal illness. (illness leading to death)

Review of the April 2012 physician's order sheet revealed an order for Hospice services dated 4/7/12.

The resident's revised care plan dated 9/5/12 recorded a handwritten entry on the care plan dated 7/6/12, which identified the resident received hospice services for end stage chronic obstructive pulmonary disease with life expectancy of less than 6 months.

On 10/2/12 at 3:40 P.M. observation revealed the resident in bed.

On 10/4/12 at 10:30 A.M. administrative licensed nurse F confirmed staff should have added hospice services to the resident's care plan.

The facility did not provide a policy that addressed care planning.

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F 279	Continued From page 10 The facility failed to create a comprehensive care plan that addressed Hospice services for this dependent resident.	F 279		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: The facility identified a census of 51 residents. The sample included 22 residents. Based on observation, record review and interview, the facility failed to perform necessary nail care for 1 of 3 residents (#35) sampled for activities of daily living (ADLs). Findings included: - Resident #35's quarterly Minimum Data set assessment (MDS) 3.0 assessment dated 7/29/12 recorded the resident with a Brief Interview for Mental Status score of 10 which indicated the resident had moderately impaired cognition. The MDS documented the resident required extensive assistance with ADLs including transfer, dressing, bathing, toileting and personal hygiene. The MDS documented the resident was occasionally incontinent of bowel and bladder. The resident's revised care plan dated 8/3/12 recorded the resident needed limited assistance with personal cares as well as set up and	F 311		

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encouragement. The care plan lacked documentation of any individualized interventions for bathing and/or nail care.

On 10/3/12 at 5:00 P.M., observation revealed the resident in the main dining room eating dinner. The resident had long chipped fingernails on his/her right hand with brown substance under the nails.

On 10/4/12 at 7:40 A.M., observation revealed untrimmed fingernails with dirty nail beds.

On 10/4/12 at 7:40 A.M. the resident stated he/she was independent with cares and bathed him/herself. The resident added that he/she would like to have his/her nails trimmed and indicated he/she did not have them trimmed for awhile.

On 10/4/12 at 10:30 A.M., direct care staff C stated the resident's bath days were Tuesdays and Fridays and staff cleaned nails. If nails needed trimmed, staff usually notified the nurse and the nurse either completed the mail care or directed the direct care staff to complete it. Direct care staff C added we have activities personnel also that do nail care.

The facility policy titled Grooming- Care of Fingernails/Toenails revised 12/02 recorded nursing assistants trimmed the residents nails, except diabetic residents with circulatory impairments including all toenails except for high risk residents. (a licensed nurse would trim those residents).

The facility failed to perform routine nail care for

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F 311	Continued From page 12 this resident.	F 311		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: The facility identified a census of 51 residents. The sample included 22 residents. Based on staff interview, record review and observation of 3 of 10 residents sampled for unnecessary medications, the facility failed to adequately monitor for potential side effects of antipsychotic	F 329		

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F 329	Continued From page 13 medications. (#16, #71 and #34) Findings included: - Resident #16's Minimum Data Set (MDS) 3.0 dated 9/2/12 recorded a Brief Interview for Mental Status score of 14 which indicated the resident was cognitively intact. The resident received antipsychotic medications 7 of 7 days prior to the assessment. The October 2012 Physician's Order Sheet ordered staff to give the resident Seroquel (anti-psychotic) 50 milligrams (mg) every bed time for the diagnosis of mood disorder with Post Traumatic Stress Disorder (PTSD) beginning on 9/20/12. The Comprehensive Care Plan for verbal aggressive behavior dated 12/23/11 and revised 9/20/12 directed staff to give the resident Seroquel with a dose reduction on 9/20/12 from 100 mg down to 50 mg. The care plan directed staff to monitor and document behaviors, administer the psychoactive medication and monitor for both effectiveness and adverse reactions. The Behavior Monitoring Record without a date listed the resident received Depakote, seroquel, xanax and effexor for the diagnosis of anxiety, mood disorder with PTSD. Staff were to monitor for the targeted behaviors yelling, cursing at staff, increased anxiety or agitation and physical abuse. The Behavior Monitoring Record did not indicate which behaviors were targeted for which medications.	F 329		

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F 329	Continued From page 14 Review of the resident's clinical record revealed a lack of monitoring for abnormal involuntary movements. Observation on 10/2/12 at 10:24 A.M. revealed the resident laid in bed awake in his/her room. During staff interview on 10/4/12 at 12:14 P.M. administrative nursing staff B acknowledged the clinical record lacked evidence staff assessed the resident for abnormal involuntary movements related to seroquel. The facility provided a policy entitled Antipsychotic Medication Log dated September 2003 which directed administrative staff or designee to round each week to assess each resident utilizing anti-psychotic medications for adequately monitoring daily, weekly behavior charting or usage of tools such as the AIMS testing. The facility failed to monitor this resident's target behaviors and for potential adverse side effects from antipsychotic medication. - Resident #34's Minimum Data Set (MDS) 3.0 dated 9/14/12 recorded a Brief Interview for Mental Status score of 13 which indicated the resident was cognitively intact. The resident received anti-depressant medication, but did not receive antipsychotic medications during the assessment period.	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175338	A. BUILDING _____ B. WING _____	10/09/2012

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F 329	Continued From page 15 The October 2012 Physician's Order Sheet documented the resident received: Clonazepam (an anti-psychotic medication) 1 milligram (mg) by mouth twice a day for mood disorder and perphenazine (an anti-depressant medication) 8 mg by mouth twice a day for Bipolar disorder (episodes of hyperactivity and depression). The resident's comprehensive care plan dated 9/1/12 lacked a Black Box Warning (BBW) for the resident's use of Clonazepam (a warning attached to some medications which the U.S. Food and Drug administration has identified with potentially severe side effects). According to the food and drug administration website, both medications Clonazepam and perphenazine can cause extrapyramidal side effects which included movement disorders. Review of the clinical record lacked documentation of an AIMS (Abnormal Involuntary Movement Scale) for the resident's use of Clonazepam and perphenazine. On 10/4/12 at 3:30 P.M. administrative licensed nurse B stated the staff missed the resident's antipsychotic Clonazepam on care planning. Administrative licensed nurse B also acknowledged the lack of AIMS testing for all residents on the skilled nursing unit. The facility policy titled Antipsychotic Medication Log revised September 2003, directed staff to adequately monitor daily and weekly behavior charting or usage of tools such as the AIMS testing.	F 329		

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F 329	Continued From page 16	F 329		

The facility failed to list all medications with BBW medication on the resident's care plan, and failed to complete AIMS testing for this resident who received psychotropic medications.

- Resident #71's Minimum Data Set (MDS) 3.0 dated 8/24/12 recorded the resident with severely impaired cognition. The resident received anti-depressant and anti-anxiety medication.

The October 2012 Physician's Order Sheet documented the resident received Clonazepam (an anti-psychotic medication) 0.5 milligram (mg) by mouth twice a day as needed for anxiety.

The revised care plan dated 9/6/12 lacked documentation of the residents as needed use of Clonazepam.

Review of the clinical record revealed a Psychoactive Medication Education form dated 8/17/12 which listed Clonazepam for anxiety. The clinical record lacked documentation of a current AIMS assessment.

On 10/3/12 at 8:05 A.M. licensed nurse G acknowledged the resident had an order for as needed Clonazepam but never knew of him/her using it.

On 10/4/12 at 3:30 P.M. administrative licensed nurse B stated staff missed resident antipsychotic Clonazepam for care planning because it was an as needed medication and rarely used. Administrative licensed nurse B also acknowledged the lack of AIMS testing for residents on the skilled nursing unit.

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F 329	Continued From page 17 The facility policy titled Antipsychotic Medication Log revised September 2003, directed staff to adequately monitor daily and weekly behavior charting or usage of tools such as the AIMS testing. The facility failed to complete AIMS testing for this resident who received psychotropic medications.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: The facility identified a census of 51 residents. The sample included 22 residents. Based on interview, record review and observation for 1 of 10 residents sampled for unnecessary medications, the facility failed to provide pharmacy services to adequately monitor for potential side effects of antipsychotic medications. (#16) Findings included:	F 428		

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F 428	Continued From page 18	F 428		

- Resident #16's Minimum Data Set (MDS) 3.0 dated 9/2/12 recorded a Brief Interview for Mental Status score of 14 which indicated the resident was cognitively intact. The resident received antipsychotic medications 7 of 7 days prior to the assessment.

The October 2012 Physician's Order Sheet ordered staff to give the resident Seroquel (an anti-psychotic) 50 milligrams (mg) every bed time for the diagnosis of mood disorder with Post Traumatic Stress Disorder (PTSD) beginning on 9/20/12.

The Comprehensive Care Plan for verbal aggressive behavior revised on 9/20/12 directed staff to give the resident Seroquel with a dose reduction on 9/20/12 from 100 mg down to 50 mg. The care plan directed staff to monitor and document behaviors, administer the psychoactive medication and monitor for both effectiveness and adverse reactions.

The Behavior Monitoring Record without a date listed the resident received Depakote (mood stabilizer), seroquel, xanax (anti-anxiety) and effexor (anti-depressant) for the diagnosis of anxiety, mood disorder with PTSD. Staff were to monitor for the targeted behaviors yelling, cursing at staff, increased anxiety or agitation and physical abuse. The Behavior Monitoring Record did not indicate which behaviors were targeted for which medications.

Review of the resident's clinical record revealed a lack of monitoring for abnormal involuntary movements.

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F 428	Continued From page 19 The Monthly Pharmacy Regimen Review from 1/11/12 - 9/17/12 did not identify the need for the facility to complete an AIMS for the resident's seroquel or the need to identify targeted behaviors for seroquel, Depakote, xanax and effexor. Observation on 10/2/12 at 10:24 A.M. revealed the resident laid in bed awake in his/her room. During staff interview on 10/4/12 at 12:14 P.M. administrative nursing staff B acknowledged the clinical record lacked evidence staff assessed the resident for abnormal involuntary movements related to seroquel and acknowledged the pharmacy consultant failed to identify the need for the facility to monitor. The facility provided a policy entitled Antipsychotic Medication Log dated September 2003 directed administrative staff or designee to round each week to assess each resident utilizing anti-psychotic medications for adequately monitoring daily, weekly behavior charting or usage of tools such as the AIMS testing The facility failed to provide adequate monitoring by consultant pharmacy staff of this resident's drug regimen.	F 428		